allergy associates of La Crosse

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____DOB:_____
Street Address: _____
City, State, Zip: _____
Phone Number:_____

Disclosed From AAOL: (or)

_____
Name (Health Facility, Physician…)

_____
Street Address

_____
City State Zip

_____
Phone Fax

Disclosed To:

_____
Name (Health Facility, Physician, Attorney…)

_____
Street Address

_____
City State Zip

_____
Phone Fax
(Required for Health Facility, Attorney)

Information to be disclose
____last 2 years chart notes ___allergy test results ___lab results ___complete medical record
___other_____

Date Information needed _____

Reason for Disclosure
__Continuing care __Personal Reasons ____Legal ____Parental/guardian communication

We reserve the right to charge a reasonable cost-based fee for producing and mailing the copies.

- I understand that I have the right to inspect or copy the information used or disclosed in the authorization.
- I understand that if I sign this authorization, I will receive the original of this signed document.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Clinic Privacy Officer.
- The Clinic may not condition treatment based on the provision that I authorize this disclosure of my health information.
- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to the Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ _____
Signature of Patient Date

_____ _____
Parent/Legal Guardian Date